Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: MEMORIAL HERMANN HOSPITAL C/O AHC HEALTHCARE RECEIVABLES MGMT 10002 BATTLEVIEW PKWY MANASSAS VA 20109-2332	MFDR Tracking #: M4-03-6463-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO. Box #: 54	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Trauma should be paid at fair and reasonable instead of per diem rate plus carve outs."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill
3. EOBs
4. Medical Records
5. Total Amount Sought - $10,861.72

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "In conclusion Texas Mutual has determined that $3670.40 is fair and reasonable payment for a 2-day surgical trauma inpatient hospital stay. Memorial Hospital failed to meet its burden of proof to establish Texas Mutual still owes Memorial Hospital after Texas Mutual's payment and that the fees paid to date fall below the statutory standard."

Principal Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
11/1/2002-11/3/2002	O, YO, D, YD, F, TR, C, YC, M, RD, TM, S, YS	Inpatient Trauma Surgery	$10,861.72	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on April 28, 2003. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on May 19, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - O – Denial after reconsideration
   - YO – REIMBURSEMENT WAS REDUCED OR DENIED AFTER RECONSIDERATION OF TREATMENT/SERVICE BILLED.
   - D – Duplicate bill

- YD – DUPLICATE APPEAL. AN APPEAL OF THE ORIGINAL AUDIT DECISION WAS PREVIOUSLY PERFORMED FOR THESE SERVICES. IF YOU DISAGREE WITH THE ORIGINAL APPEAL DECISION, YOU MAY REQUEST MEDICAL DISPUTE RESOLUTION THROUGH THE TEXAS WORKER'S COMPENSATION COMMISSION.
- F – Fee guideline MAR reduction
- TR – REIMBURSED IN ACCORDANCE WITH THE TEXAS HOSPITAL FEE GUIDELINE.
- C – Negotiated contract price
- YC – REIMBURSED PER NEGOTIATED CONTRACT WITH EOS MANAGED CARE SERVICES, INC. FOR QUESTIONS REGARDING CONTRACT RATES, CONTACT INQUIRIES DEPT. AT 1-800-32-5888 EXT. 5889.
- M – No MAR
- RD – THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011(B).
- TM – SERVICES WERE REIMBURSED IN ACCORDANCE WITH THE CARRIER'S FAIR AND REASONABLE; COST DATA IS UNAVAILABLE FOR YOUR FACILITY AT THIS TIME. ADDITIONAL REIMBURSEMENT MAY BE CONSIDERED UPON RECEIPT OF THIS INFORMATION.
- S – Supplemental payment
- YS – SUPPLEMENTAL PAYMENT

2. The carrier denied services using the denial code C "Negotiated contract price" and denial code YC "REIMBURSED PER NEGOTIATED CONTRACT WITH EOS MANAGED CARE SERVICES, INC. FOR QUESTIONS REGARDING CONTRACT RATES, CONTACT INQUIRIES DEPT. AT 1-800-32-5888 EXT. 5889." Review of the submitted documentation finds no copy of the contract or documentation to support a contractual agreement between the parties to this dispute. The Division concludes that these EOB denials are not supported. The services will therefore be reviewed per applicable statutes and Division rules.
3. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 813.42. The Division therefore determines that this inpatient admission is a trauma admission and shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
4. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. Division rule at 28 TAC §133.307(g)(3)(C)(ii), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "the requestor's reasoning for why the disputed fees should be paid." Review of the submitted documentation finds no documentation of the requestor's reasoning for why the disputed services should be paid. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(ii).
7. Division rule at 28 TAC §133.307(g)(3)(C)(iii), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor did not state how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iii).
8. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).

9. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor did not submit a position statement for consideration in this dispute.
   - The requestor's rationale for increased reimbursement from the *Table of Disputed Services* states that "Trauma should be paid at fair and reasonable instead of per diem rate plus carve outs."
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.
10. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

	Grayson Richardson	**9/17/2010**
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.